2007 CPT/HCPCS Coding Changes for the Military Health System

Presented By The TMA

Uniform Business Office

Program Manager

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The MHS buys a license for most of the MTFs. If you are a contractor working somewhere other than an MTF, the license may not cover you.

How to determine if your MTF has been using a deleted code

- Go to: http://www.tricare.mil/ocfo/mcfs/ubo/index.cfm
- Scroll about 2/3 of the way down the page
- Look for the announcement about this presentation

- **TITLE:** 2007 CPT/HCPCS Updates
  DATES and TIMES:
- Wednesday, 27 December 2006 - 0800, 1000, and 1300
- Thursday, 28 December 2006 - 0800, 1000, and 1300
- Wednesday, 3 January 2006 - 0800, 1000, and 1300
  ALL times noted are EASTERN STANDARD.
  CONTENT: Presentation slides on the new codes will be sent under separate cover. Files for downloading are posted below.
  2007 Deletions xls 3800.0 KB
  CALL-IN NUMBERS: 866-866-2244, Participant Code: 6087779#
  For questions regarding this teleconference, please contact the TMA UBO Program Manager at 703-681-3492, ext. 4068 or

  contact the UBO Help Desk - 703-575-5385, ubo.helpdesk@altarum.org.

- Click on the “2007 Deletions” file
- Auto filter the DMIS IDs and look at your DMIS

How to determine if your MTF has been using a deleted code

- Many smaller MTFs will not even be listed as they did not use any of the deleted codes last year
- Some (e.g., Shaw) will only have a few codes, such as the ever popular 3000F and 3002F which were replaced by 3076F, 3077F, 3078F, 3079F and 3080F

Objective 1

- By the end of this briefing, students will be able to:
  - State the three major MHS systems that need to “load” the updated 2007 CPT/HCPCS tables
  - State the errors which will occur if the tables are not loaded “concurrently”
  - Make a recommendation to their System Administrator regarding dates on which to “load” the three major MHS systems’ updates

Objective 2

- By the end of this briefing, students will be able to:
  - List the code groups which will have the greatest change on MHS coding
  - Match why various codes were added, deleted, and changed

Objective 3

- By the end of this briefing, students will be able to:
- Match the Category II topics or clinical conditions to their abbreviations
- Advise their MTFs on the collection of category II codes (hint: probably not worth the time to collect)

This Brief Will NOT Cover

- CPT codes:
  - Inpatient Procedures
  - Radiology
  - Laboratory
  - Procedures outside the MTF (e.g., home)
- Most HCPCS (except for the Emergency Department institutional component) codes:
  - Dental
  - Durable Medical Equipment
  - Hospice
  - Oncology
  - J-codes and C-codes

Three Major MHS Computer Systems

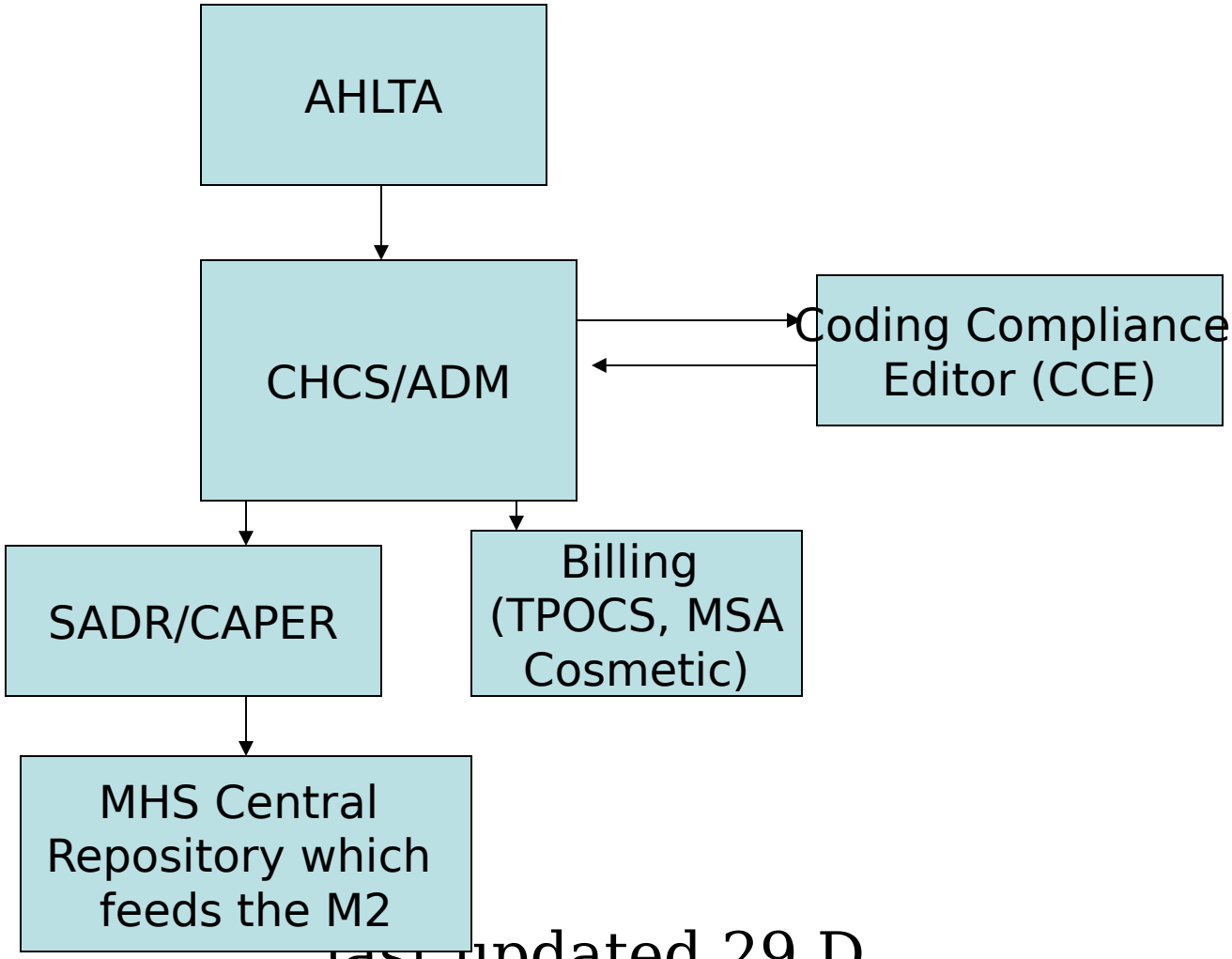
- MHS - Military Health System
- CHCS - Composite Health Care System
- AHLTA – who knows, could be Armed Forces Healthcare Longitudinal Tracking Application, could be Awe Heck Let's Try Again, could just be AHLTA…
- CCE – Coding Compliance Editor

- CHCS – "backbone" of the MHS computer system. Has the Ambulatory Data Module (ADM) where encounters can be coded directly. AHLTA and CCE flow to CHCS. CHCS feeds to the MHS central repository.

When to Run, When to Sit Tight

- AHLTA will not be ready to “run” until 22 Jan 2007
- If you code in AHLTA a valid 2006 code which is deleted in 2007, the encounter will edit when it flows to CHCS
- If you update CCE, but not CHCS or AHLTA, lots of edits
- Last update on 22 Dec 06 is the usual CHCS test location declined to do the testing until AHLTA is ready, so everyone may have to wait as CHCS won’t be ready until the same time as AHLTA

When to Run, When to Sit Tight



When to Run, When to Sit Tight

- MHS Relative Value Units (RVUs) for new CPT/HCPCS are assigned in May, and applied for the entire calendar year
- Rates for new CPT/HCPCS codes are usually available in June of that year, and not applied retroactively
- CMS does not have a 90 day conversion window, but most other insurance companies do, so if code conversion is delayed, and 2006 codes are used in 2007, many insurers will pay

When to Run, When to Sit Tight

- BOTTOM LINE: Strongly **recommend** you
  - Load the new MHS tables in CHCS and ALHTA at the same time, AND
  - Don’t load the new 3M tables in CCE until you load the new 2007 CPT/HCPCS in CHCS (ADM) and AHLTA

Code Groups Which Will Have the Greatest Change on MHS Coding

- Long-term Anticoagulant Monitoring
- Emergency Room Institutional
- Regional Anesthesia
- Office and “Ambulatory Procedure Visits”

Anticoagulation Management

- **Not to be reported if patient managed by outpatient pharmacist nor nurse anticoagulation clinic. If nurse or outpatient pharmacist, continue to use S9401, for which we assigned RVUs last year**
- International Normalized Ratio (INR) tests – standards of care basis (initial is 8, subsequent is 3)
- May not report work or time twice

Anticoagulation Management

- **99363** Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)

- **99364** each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)

Anticoagulation Management

- In MHS, if there are telephone calls where the encounters meet the definition of a “count,” code the encounter with E&M of “99499” and diagnosis of V58.61.
- Code the 99363 or 99364 AFTER the service is complete. Use the anticoagulation management code the 1st encounter for this care after you completed the initial 90 days or subsequent 90 days.
- If the encounter when you are coding the 90 days is during an E&M, code the E&M (not including the time/evaluation/history/decision making involved in the anticoagulation management) with a modifier 25.
- The diagnosis will usually be V58.61.

Anticoagulation Management

- Example: Established patient newly diagnosed with congestive heart failure (super secret category II code abbreviation “HF”) and paroxysmal or chronic atrial fibrillation. Patient was prescribed Warfarin therapy.
  - This visit code the E&M based on documentation. Consider using the CPT category II 4012F “Wafarin therapy prescribed” so you can easily tell when the “90-day clock” starts running
- Patient seen for other stuff during the next 90 days. Do not include the anticoagulation management documentation in the E&M determination.
- Patient seen at day 95 and has 8 International Normalized Ratio (INR) testing, adjustments, etc documented over the past 95 days. Code the E&M of the current visit based on non-anticoagulation management documentation, with modifier 25. Code the 99363 as an E&M.

Emergency Department Institutional

- Until now, there were codes for
  - The professional component of an Emergency Department visit (99281-99285)
  - The professional and institutional components of procedures (for any procedure considered an outpatient procedure)
- But, no code to separately code the institutional component of the Emergency Department visit

Emergency Department Institutional

- For instance:
- “Normal adult patient” reports with laceration. Code minor professional component (99281) and suture
- “High-on-who-knows-what-combative-patient” brought in by authorities (who have another call and leave) with laceration. Code minor professional component (99281) and suture
  - No way to indicate it took two technicians to hold the patient for 15 minutes while the nurse tried to clean the wound prior to the doctor doing the suturing, in all an additional 45 minutes of extra staff time

Emergency Department Institutional

G0380		LEV 1 HOSP TYPE B ED VISIT
G0381		LEV 2 HOSP TYPE B ED VISIT
G0382		LEV 3 HOSP TYPE B ED VISIT
G0383		LEV 4 HOSP TYPE B ED VISIT
G0384		LEV 5 HOSP TYPE B ED VISIT

- These are the HCPCS descriptions.
- At this time, each institution (e.g., civilian institution, such as the Mayo Clinic can have one way, and the Rochester Clinic another) needs to differentiate the various levels.
- The MHS needs to determine how it differentiates the levels.

Emergency Department Institutional

- Why nurse/technician face-to-face with patient minutes?
  - Procedures already include both professional and institutional components
  - Facilities are fixed costs, they stay the same regardless of volume
  - Supplies are usually included in the procedure (e.g., casting supplies)
  - Nurse/technician time is a variable

Emergency Department Institutional

- How the MHS will differentiate:
  - Minutes of face-to-face nurse/technician interaction with the patient, which is not included in a procedure code.
  - For instance,
    - if a privileged provider provides an injection and codes the injection, the nurse/technician time is included in the practice expense of the provider coded procedure.
  - On the other hand,
    - if the provider orders an injection which is done by the nurse/technician, then the procedure would not be separately coded and the nurse/technician time would be used in the determination of the level of the institutional component.

Emergency Department Institutional – HCPCS Narrative

- Institutional Component of a hospital emergency visit provided in a department or facility of the hospital.
- The department or facility must meet at least one of the following requirements:
  - (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;
  - (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
  - (3) during the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment

Emergency Department Institutional

- MHS method of determining different levels. Times are approximate based on documentation.
  - **G0380 Level 1. 1-15 minutes of face-to-face** nurse/technician interaction with the patient, which is not included in a procedure code.
  - **G0381 Level 2. 16-30 minutes of face-to-face** nurse/technician interaction with the patient, which is not included in a procedure code.
  - **G0382 Level 3. 31-45 minutes of face-to-face** nurse/technician interaction with the patient, which is not included in a procedure code.
  - **G0383 Level 4. 46-60 minutes of face-to-face** nurse/technician interaction with the patient, which is not included in a procedure code.
  - **G0384 Level 5. Greater than 60 minutes of face-to-face** nurse/technician interaction with the patient, which is not included in a procedure code.

Emergency Department Institutional

- Nurse/Technician time based on documentation
  - Did technician adjust crutches and teach the patient how to properly use the crutches? Did the technician just adjust the crutches as the patient had used crutches previously?
    - This would only apply if there was no procedure (e.g., no strapping or casting). If there is a codable procedure, the nurse/technician time is included in that code's institutional component
  - Did the technician constantly monitor the patient (e.g., vital signs documented every few minutes) or check the patient periodically (e.g., times on notes indicate patient still applying pressure on his wound with minor bleeding documented every 20 minutes)

Emergency Department Institutional

- When coding,
  - The professional component will be entered in the E&M field
  - The institutional will be the last procedure, unless there are more than 3 procedures, in which case the institutional will be the 4th procedure, linked to the diagnosis(es) which caused the face-to-face time
    - If the only face-to-face time is check-in and check-out, then the diagnosis which caused the patient to come to the Emergency Department will be linked to the G0380/1/2/3/4.
  - No need to list nurse/technician as additional provider

Emergency Department Institutional

- NOTE: When there is patient movement, which is not included in the procedure, include the time the technician spent transporting the patient. For instance, if the patient is taken to radiology, the operating room or the ward on a gurney or in a wheel chair, add the time WITH the patient. Do not add the time the technician took to walk back to the Emergency Department without the patient.

Anesthesia

- Deleted code
  - 01995 Regional intravenous administration of local anesthetic agent or other medication (upper or lower extremity)
- Instead of 01995, use the normal anesthesia codes, which are usually based on location
- Coded in the MHS 1,225 times in FY2006

Approximately 671 New Codes

- 2 - E&M (anticoagulation)
- 2 - Anesthesia, but one MAJOR deletion
- 2 - H-codes
- 26 – Office type procedures (10 non-discountable, 16 discountable)
- 42 – Ambulatory Surgery Center type

- 165 – “HEDIS” type (60 – CPT Category II; 105 – HCPCS)
- 81 - HCPCS Oncology
- 114 - Durable Medical Equipment

- 47 - Inpatient procedures
- 50 - Radiology procedures (tell radiology!)
- 11 - Laboratory procedures (tell laboratory!)

- 9 -Hospice CPT
- 34 - J-codes
- 24 - A-codes/C-codes
- 22- Dental

Many other groups of codes expanded/ changed

- Substance Abuse Rehabilitation Center

H0049		ALCOHOL/DRUG SCREENING
H0050		ALCOHOL/DRUG SERVICE 15 MIN

Skin

New	Deleted	Nomenclature	ASC Code
15003	15001	PREP OPN WNDS,TRNK;+100 SQCM/	1
15004	15000	PREP OPN WNDS,FCE;1ST 100 SQCM	2
15005	15001	PREP OPN WNDS,FCE;+100 SQCM	1
15731		FOREHD FLAP PRESRV,VASCPEDICLE	3
15830	15831	EXCSN SK;AB,INFRAUMBILIC PANCT	3
15847	15831	EXCSN SK&SUBQ TISS,ABDOMEN	3
17311	17304	MOHS,W SURG;1ST STG,UP 5 BLCKS	T
17312	17305,17306,17307	MOHS,W SURG;ADD 1ST STG,UP 5BL	T
17313		MOHS; 1ST STAGE,UP 5 TISS BLCK	T
17314	17305,17306,17307	MOHS;ADD 1ST STG,UP 5 TS BLCKS	T
17315	17310	MOHS,ADD BLCK AFT 1ST 5 BLOCK	T
19105	0120T	ABLAT,CRYOSURG,FIB,US GDNCE,EA	T

Skin (replacement codes)

- 15002 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture of **trunk, arms, legs**; first 100 sq cm or 1% of body area of **infants and children**

- 15003 each additional 100 sq cm or each additional 1% of body area of **infants and children** (List separately in addition to code for primary procedure)

Skin (replacement codes)

- 15004 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, **face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits**; first 100 sq cm or 1% of body area of **infants and children**

- 15005 each additional 100 sq cm or each additional 1% of body area of **infants and children** (List separately in addition to code for primary procedure)

Excision, Excess Skin

- 15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
  - Used after bariatric surgery when the patient looses a significant amount of fat to prevent the occurrence of recurring rashes, skin maceration, and yeast infections that develop in the abdominopelvic fold.
- **Be careful with this one, I'm seeing it miscoded. For instance, you would not expect to see it in "Newborn nursery" as that would be a circumcision; you would not expect it in Family Practice, Physical Therapy…**

Add-on Excision, Excess Skin

- This is an add-on code to use with 15830
  - 15847 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
    - Added to allow reporting the various procedures that might also need to be performed, following panniculectomy including (SOME or ALL depending on the patient)
      - Transposition of the umbilicus
      - Undermining to the coastal margin (including ligation of perforating vessels
      - Imbrication (overlapping of tissue layers in the wound closure) of the rectus diastasis
      - Lateral contouring imbrication
      - **Suction assisted liposuction**
  - Note: code abdominal wall hernia repair separately
  - **Note: code 17999 to report other abdominoplasty procedures (e.g., TUMMY TUCKS)**

Mohs Surgery

- Mohs Codes 17304-17310 are deleted
- New Codes 17311-17315 add to more accurately describe Mohs surgery procedures based on anatomic site
  - Codes now specify the anatomic site to better distinguish between the work involved in treating tumors.
  - The new and deleted codes are further differentiated according to the unit of service

Mohs Surgery

- 17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), **head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels**; first stage, up to 5 tissue blocks

- 17312 each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

Mohs Surgery

- 17313 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the **trunk, arms, or legs**; first stage, up to 5 tissue blocks

- 17314 each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

Mohs Surgery

- +17315 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)
- This is an add-on code to be used with 17311-17314

Mohs Surgery Example

- A patient underwent Mohs Micrographic surgery on the trunk
- 1st stage 6 blocks-17313 (initial 5 blocks) and 17315 (up to 5 more blocks, but in this case just 1) x 1
  - 5 blocks (17313) + up to 5 more (17315) = 6 blocks total
- 2nd stage 8 blocks-**17314** (additional stage) and 17315 x 1
- 3rd stage 4 blocks-**17314**
- 4th stage 5 blocks-**17314**
  - Correct codes to report:
    - 17313 x 1, **17314** x 3 and 17315 x 2

Cryosurgical Fibroadenoma Ablation

- 19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma
  - Replaced “temporary” code 0120T
  - If two adjacent fibroadenomas are treated with one insertion of the cryoprobe, the code should only be reported once

Mastectomy Renumbering

- New subheading under “Breast – Excision” just for “Mastectomy Procedures”
  - Added to segregate the eight mastectomy procedure codes 19140-19240
  - Codes 19140-19240 and all of the related cross-references are relocated and renumbered

Mastectomy

- 19300 Mastectomy for gynecomastia
- 19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
- 19302 with axillary lymphadenectomy
- 19303 Mastectomy, simple, complete
- 19304 Mastectomy, subcutaneous
- 19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes
- 19306 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
- 19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

Destruction of Lesions - Revised

- 17000-17004: Destruction of premalignant lesions (eg, actinic keratoses)
  - Language deleted - Other than skin tags or cutaneous vascular proliferative lesions
- 17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
  - Language deleted - Flat warts, molluscum contagiosum, or milia

Radius and Ulnar Fractures

- Four codes established to more accurately describe variations in work required to repair fractures of the distal radius and ulnar styloid bones
  - 25606 Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation
  - 25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
  - 25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments
  - 25609 with internal fixation of 3 or more fragments

Circumcision

- 54150 Circumcision, using clamp or other device with regional dorsal penile or ring block
- 54160 Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or fewer)
- 54161 older than 28 days of age

- Revised to more specifically describe age of patient
- Code 54150 further revised to specify type of penile block provided. Use modifier 52 with 54150 if performed without a nerve block

Hymenotomy, simple incision

- 56442 Hymenotomy, simple incision
  - Replaces deleted code 56720, and places in correct place in code sequence

Hysterectomies, Laparoscopic

- New codes, 58541-58544 and 58548
  - Describe various laparoscopic hysterectomy procedures
  - Included components of 58541-58544
    - Pelvic examination under anesthesia (57410)
    - Laparoscopy with or without collection of specimens (49320), myomectomy with excision of one to four myomas (58140)
    - Total abdominal hysterectomy (58150)
    - Laparoscopic removal of adnexal structures (58661)
    - Laparoscopic fulguration of oviducts (58670)
    - Laparoscopic occlusion of oviducts by a device such as a band or clip (58671)

Hysterectomies, Laparoscopic

- 58541 Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
- 58542 with removal of tube(s) and/or ovary(s)
- 58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
- 58544 with removal of tube(s) and/or ovary(s)
- 58548 Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed

Ophthalmology

- 92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report
  - Intended to be reported when topography is not performed in conjunction with keratoplasty procedures (65710, 65730, 65750 and 65755)
  - Procedure previously reportable as
  - S0820 – Computerized corneal topography, unilateral (had .35 MHS RVUs)

Ventilator Management

- 94002- 94004 are not separately reported in conjunction with the evaluation and management services codes 99201-99499 –
  - If done by attending, will not be coded separately
  - If done by technician for inpatient, is part of institutional and will not be coded separately
  - Intraservice period includes the services provided by the physician while the physician is present on the patient's hospital floor, reviewing the patient's chart, seeing the patient, writing notes, communicating with other health care professionals and the patient's family/caregiver
- 94002 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day
- 94003 hospital inpatient/observation, each subsequent day

Inhalation Treatment for Acute Airway Obstruction

- 94644 **Continuous** inhalation treatment with aerosol medication for acute airway obstruction; first hour
- 94645 each additional hour (List separately in addition to code for primary procedure)
  - Not the same as 94640 in that the treatment administered in code 94640 is administered several times a day at short intervals (eg, 10 minutes), whereas continuous inhalation treatment is
    - Administered for longer periods and then discontinued; a higher dosage of medication is administered in continuous inhalation treatment; and different equipment is used in administering continuous inhalation treatment.
    - Codes 94644 and 94645 are time-based codes
  - Code 94644 should be reported for the first hour of treatment
  - Add-on code 94645 should be reported in conjunction with code 94644 for each additional hour of treatment
  - If continuous inhalation treatment is administered for less than 1 hour, code 94640 should be reported instead of code 94644

Traditional Nebulizer Treatment

- **94640** Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPD) device)
- (For more than one inhalation treatment performed on the same date, append -modifier 76)

Medical Genetics Counseling

- Code 96040 is intended to report the services provided by a **trained genetic counselor, not by a physician (who would use an E&M for one-on-one and 99078 for a group).**
- Identify the specific and intensive efforts necessary to provide genetic counseling services to patients that may request or require this special type of service
- Genetic counseling is a communication process that deals with the human problems associated with the occurrence, or the risk of an occurrence, of a genetic disorder in the family
  - These codes may include obtaining a
    - Structured family genetic history
    - Pedigree construction
    - Analysis for genetic risk assessment
    - Counseling of the patient and family
  - These services may be provided during
    - One or more sessions and may include a review of medical data and family information, face-to-face interviews, and counseling services
  - Report one time unit for every 30 minutes of services provided FACE-TO-FACE

Sneaky Guys

- CPT/HCPCS codes can be updated multiple times during the year
- CCE has a different code set than the MHS code set
- Not all coding books are the same, for instance, the Ingenix CPT code book has codes which were announced 1 July 2006 which was too late for the AMA CPT 2007 book
- A bunch are not in the Ingenix CPT book
- In the MHS master list under line 680 “Errata Add”
- BOTTOM LINE: Category II and III so no big deal – use them if you feel like it (well, the category III you have to use if they apply…)

2007 Errata Add (might not be in your hard copy coding book)

ERRATA ADD	
0171T	INS,PST SPINOUS DISRACN(REM,BN/LGAMNT,INS&IMG),LUMBR;1 LVL
0172T	INS,PST SPINOUS DISRACN(REM,BN/LIGAMENT),LUMBR;EA ADD LVL
0173T	MON, INTRAOC PRESS VITRECTOMY SURG (LST SEP ADD CD, 1 PROC)
0174T	CAD W FURT PHYS REV, W/WO DIG FLM RAD IMG, PER CON 1 INTERP
0175T	CAD W FURT PHYS REV,WWO DIG FLM RAD IMG,CHST RAD,REM,1INTERP
0176T	TRNSL DILATION, AQUEOUS OUTFLOW CANAL; WO RETAIN, DVCE/STNT
0177T	TRNSL DILATION, AQUEOUS OUTFLOW CANAL; W RETAIN, DVCE/STNT
0505F	HEMODIALYSIS PLAN OF CARE DOCUMENTED (ESRD)1
0507F	PERITONEAL DIALYSIS PLAN OF CARE DOCUMENTED (ESRD)1
1040F	DSM-IV CRITERIA, MAJ OR DEPRESSIVE DISORDER DOCUMENTED (MDD)1
1050F	HISTORY OBTAINED REGARDING NEW OR CHANGING MOLES (ML)5
1055F	VISUAL FUNCTIONAL STATUS ASSESSED (EC)5
2019F	DLATED MAC X PERF,DOC,PRES/ABSNCE,MAC THCKNG/HEM,LVL,MAC DEG
2020F	DILATED FUNDUS EVAL PERF W/IN 6 MONTHS PRIOR CATRCT SURG
2021F	DLATED MAC/FNDUS X PERF,DOC,PRES/ABSNCE,MAC EDEM, SVR, RETIN
2027F	OPTIC NERVE HEAD EVALUATION PERFORMED (EC)5
2029F	COMPLETE PHYSICAL SKIN EXAM PERFORMED (ML)`
2030F	HYDRATION STATUS DOCUMENTED, NORMALLY HYDRATED (PAG)1

2007 Errata Add (might not be in your hard copy coding book)

2031F	HYDRATION STATUS DOCUMENTED, DEHYDRATED (PAG)1
3008F	CHEST X-RAY NOT ACCESSIBLE1(CAP)
3033F	OXYGEN SATURATION EQUIPMENT NOT ACCESSIBLE1 (CAP)
3044F	MOST RECENT HEMOGLOBIN A1C LEVEL <7.0% (DM)2,4
3045F	MOST RECENT HEMOGLOBIN A1C LEVEL 7.0 û 9.0 % (DM)2,4
3073F	CATRCTAXIAL LN,CORN PWR MS/MTH ,IOL PWR CAL DOC 6M PRIOR SUR
3074F	MOST RECENT SYSTOLIC BLOOD PRESS <130 MM HG (DM)2,4, (HTN)1
3075F	MOST RECENT SYSTOLIC BLOOD PRESS 130 - 139MM HG
3082F	KT/V <1.2 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)1
3083F	KT/V=TO/>1.2 &<1.7 (CLEARANCE, UREA (KT)/VOL (V)) (ESRD)1
3084F	KT/V >=1.7 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)1
3085F	SUICIDE RISK ASSESSED (MDD)1
3088F	MAJ OR DEPRESSIVE DISORDER, MILD (MDD)1
3089F	MAJ OR DEPRESSIVE DISORDER, MODERATE (MDD)1
3090F	MAJ DEPRESSIVE DISORDER, SEVERE WO PSYCHOTIC FEATURES (MDD)1
3091F	MAJ OR DEPRESSIVE DISORDER, SEVERE W PSYCHOTIC FEATURES (MDD)
3092F	MAJ OR DEPRESSIVE DISORDER, IN REMISSION (MDD)1
3093F	DOCENT, NEW DX, INIT/RECURRENT EPISD, MAJ DEPIVE DIS (MDD)1
3095F	CENTRL DUAL-ENERGY X-RAY ABSORPTIOMETRY(DXA)RESULTS DOCENTED
3096F	CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) ORDERED (OP)5
4005F	PHARMACOLOGIC TX(OTX MINS/VITAMINS),OSTEOPOROSIS PRESCRIBED(

2007 Errata Add (might not be in your hard copy coding book)

4007F	ANTIOXIDANT VITAMIN/MIN EMENT PRESCRIBED/RECOMMENDED (EC)5
4019F	DOC,COUNS XERCSE&EITX BTH CA&VIT D USE/COUNS RGRDNG CA&VIT D
4051F	REFERRED FOR AN ARTERIO-VENOUS (AV) FISTULA (ESRD)1
4052F	HEMODIALYSIS VIA FUNCTING ARTERIO-VENOUS (AV) FIST (ESRD)1
4053F	HEMODIALYSIS VIA FUNCTING ARTERIO-VENOUS (AV) GRAFT (ESRD)1
4054F	HEMODIALYSIS VIA CATHETER (ESRD)1
4055F	PATIENT RECEIVING PERITONEAL DIALYSIS (ESRD)1
4056F	APPROPRIATE ORAL REHYDRATION SOLUTION RECOMMENDED (PAG)1
4058F	PEDIATRIC GASTROENTERITIS EDUCATION PROVDE CAREGIVER (PAG)1
4060F	PSYCHOTHERAPY SERVICES PROVIDED (MDD)1
4062F	PATIENT REFERRAL FOR PSYCHOTHERAPY DOCUMENTED (MDD)1
4064F	ANTIDEPRESSANT PHARMACOTHERAPY PRESCRIBED (MDD)1
4065F	ANTIPSYCHOTIC PHARMACOTHERAPY PRESCRIBED (MDD)1
4066F	ELECTROCONVULSIVE THERAPY (ECT) PROVIDED (MDD)
4067F	PT REFERRAL, ELECTROCONVULSIVE THERAPY (ECT) DOCENTED (MDD)1
5005F	PATIENT COUNSELED SELF-EXAMINATION, NEW/CHANGING MOLES (ML)5
5010F	FNDNGS,DILATED MAC/FUNDUS X COMMD PHYS MANAGNG DIABETES CARE
5015F	DOCENT,COMM FX OCCUR PT WAS/SHOULD BE TST/TRTD,OSTEOPOROSIS

Category II Codes

- Only use if someone at your MTF/Service is actually going to look at the data
- Category II codes are patient safety practices, or subcomponents of an E&M or procedure; no RVUs
  - Commonly associated with the National Committee on Quality Assurance (NCOA) **Health Employer Data Information Set (HEDIS®)**
- Updated up to 3 times per year, BUT MHS code sets are updated annually – so only use those available as of 1 Jan 2007
- Usually use the entire set for a topic/condition, not just one (e.g., use all category II diabetic codes if you will be using any)

Category II Codes

- Category II Modifiers
  - **Do not use at this time as they are not available in the MHS code sets until July 2007 at the earliest**
  - Use only if measure was considered but not done
    - 1P – Not done due to medical reasons such as not indicated (e.g., absence of organ, already received) or contraindicated (e.g., allergic)
    - 2P – Not done due to patient reasons such as patient declined, religious or social reasons
    - **3P – Not done due to System reasons such as not available or insurance won't cover**

Category II Codes

- Composite codes, 0001F, 0005F, 0012F (new) – use only if ALL subcomponents listed are done
- Clinical Condition or Topics include:
  - Asthma (Asthma) - Eye care (EC)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Community-Acquired Bacterial Pneumonia (CAP)
  - Coronary Artery Disease (CAD)
  - Diabetes (DM) - Heart Failure (HF)
  - Hypertension (HTN) -Major Depressive Disorder (MDD)
  - Melanoma (ML) - Osteoprorsis (OP)
  - Osteoarthritis, Adult (OA)
  - Prenatal-Postpartum Care (Prenatal)
  - Preventive Care & Screening (PV)
  - Pediatric Acute Gastroenteritis (PAG)

Category II Codes

- **Use category II codes after all other codes (including E-codes), as the first 4 codes are currently sent to the MHS central repository, but all the other codes will be on your server (and you are the one who will be doing the research)**

- Still use the DoD Extender codes instead of the
  - 1038F Persistent asthma (mild, moderate or severe)
  - 1039F Intermittent asthma

Category II Codes

- New codes 1034F-1036F
  - Reported to identify
    - (1) a current tobacco smoker (code 1034F)
    - (2) a smokeless tobacco user (code 1035F), or
    - (3) individuals that do not use tobacco
  - These codes are intended to be
    - Reported in conjunction with code 1000F, which identifies the assessment of the patient's tobacco use (or lack thereof)

Category II Codes - Diabetes

- Are to be coded with the date done, not the date of the report
- Codes are in groups – only use one of the group, e.g.,
  - 2022F – Documentation, review and interpretation of a dilated retinal eye exam
  - 2024F – Documentation, review and interpretation of seven standard field stereoscopic photos
  - 2026F – Documentation and review of validated eye imaging to match diagnosis from seven standard field stereoscopic photos results

Category II Codes - Diabetes

- There could be category I codes or HCPCS codes that also meet the indication
  - **2028F - Performance of a foot examination that includes visual examination of the foot, sensory examination with monofilament, and pulse exam (need all three components)** (new this year!!!)
  - G0245 – Initial E&M of DM patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS)…
  - G0246 – Follow-up E&M of DM patient with LOPS
  - G0247 – Routine foot care of DM patient with LOPS

Category II Codes

- 6005F Rationale (eg, severity of illness and safety) for level of care (eg, home, hospital) documented (CAP)
  - Notice the “(CAP)” – this is for community acquired bacterial pneumonia patients
  - Don’t use to indicate other procedures done at an unusual level of care (e.g., brain surgery in the doctor’s office) had documented justification of care (e.g., cerebral hemorrhage at McMerdo base during the winter)

Rhinophototherapy (Category III)

- 0168T Rhinophototherapy, intranasal application of ultraviolet and visible light, bilateral
  - Added to report rhinophototherapy that
    - Utilizes a special instrument to deliver both visible and ultraviolet light to the nasal cavities to suppress the immune effects of allergic rhinitis
  - Because therapeutic benefits of ultraviolet light on atopic dermatitis have been established, and clinical similarity between atopic dermatitis and allergic rhinitis exist this procedure is used for the treatment of allergic rhinitis

Fecal-occult blood test

- G0107 Deleted, now use 82270.
  - Medicare has announced its plan to retire fecal-occult blood test (FOBT) code **G0107** on Jan. 1, 2007, in an effort to enhance clarity in FOBT codes
  - Medicare wants you to use CPT® code **82270** instead

Elevated Blood Pressure

- Deleted (if you look at the excel file, the deletes are highlighted in green)

3000F		BLOOD PRESSURE 140/90 MM HG
3002F		BLOOD PRESSURE >140/90 MM HG

- Replaced by (if you look at the excel file, the new code are highlighted in yellow)

3076F		RECENT SYSTOLIC BP <140 MM HG
3077F		RECENT SYSTOLIC BP >or =140 MM HG
3078F		RECENT DIASTOLIC BP <80 MM HG
3079F		RECENT DIASTOLIC BP 80-89MM HG
3080F		RECENT DIASTOLIC BP>or =90 MM HG

Quiz

- State the three major MHS systems that need to “load” the updated 2007 CPT/HCPCS tables
- State the errors which will occur if the tables are not loaded “concurrently”
- Make a recommendation to their System Administrator regarding dates on which to “load” the three major MHS systems’ updates

Quiz

- List the code groups which will have the greatest change on MHS coding
- Match why various codes were added, deleted, and changed

Quiz

- Match the Category II topics or clinical conditions to their abbreviations
- Advise their MTFs on the collection of category II codes (hint: probably not worth the time to collect)